NJNG YOUTH CAMP
CAMP DATES: 13-19 JULY 2008
CAMPER APPLICATION
FILL THIS OUT IF YOU ARE AGES 9-13

PLEASE READ CAREFULLY AS THERE ARE MANY CHANGES!!

Dear Parent/Guardian:

Attached is a camper application packet for the NJNG Youth Camp. Please fill it out **completely** and return it to the address on the bottom of this page by **15 May 2008**. **NO EXCEPTIONS WILL BE MADE AFTER THIS DATE. ALL** pages must be filled out and mailed as a **complete package,** failure to do so will result in the application being returned to you as incomplete. Your child does not go on the Youth Camp Roster until all documents are complete and payment is made.

Boys and Girls, ages **9-13** are invited to apply. **ALL CAMPERS MUST BE, the Child/Grandchild/Legal dependent of an active or retired New Jersey National member. All children must be between the ages of 9-13 as of the first day of camp. Boys and Girls, ages 13, will now be participating as campers in one company. They are required to pay the $100.00 fee and follow the same rules as campers. Applications will be accepted on a first come, first serve basis.**

The medical forms included in the packet are a prerequisite for acceptance into the program. State Law requires them and we cannot make exceptions. The deadline for applications is **15 May 2008.** Again, all complete applications will be processed on first come and complete basis. Please submit as soon as possible.

If your child is on medication, the attached **"permission to medicate"** and the **"Standing Orders"** form must be completed and **signed by your child's Physician and also signed by a parent/guardian**. It applies to both prescription and over-the-counter medication. **It is only required if your child will be taking medication while at camp. The "Permission to Medicate" form should be GIVEN TO THE CAMP NURSE AT IN-PROCESSING. DO NOT SEND BACK WITH APPLICATION.**

COST: $100.00 per child. Make check payable to NJNG Family Programs Local Fund. This fee supplements the cost of camper gear as well as activities and meals. All checks will be cashed upon receipt of the completed application. ($75.00 refund if child cancels more then 14 days before camp, no refund if child cancels within 14 days of camp. If refund is required, the returned check will NOT be issued until the end of Youth Camp week.)

THANK YOU FOR YOUR INTEREST IN THE NJNG YOUTH CAMP
MAILING ADDRESS:
Joint Force Headquarters
ATTN: Family Programs
3650 Saylors Pond Road
Fort Dix, NJ 08640

For more information, please call the State Family Programs Office at 609-562-0636. If accepted, you will receive your confirmation packet by mail. In that mailing, you will be notified of time to report and a list of items to bring with you to camp.

CAMPER APPLICATION (ages 9-13)
NEW JERSEY NATIONAL GUARD YOUTH CAMP
SEA GIRT, NEW JERSEY
13-19 July 2008

PLEASE PRINT. APPLICATIONS WILL BE ACCEPTED UNTIL 13 JUNE 2008. ALL AREAS MUST BE COMPLETED OR APPLICATION WILL BE RETURNED. APPLICATIONS WILL BE ACCEPTED ON A FIRST COME, FIRST SERVE BASIS.

Child's Name: _____ Sex: (circle) M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____

Age: _____(as of the first day of camp) Date of Birth: _____/_____/_____

T-Shirt Size (Adult sizes): S M L XL XXL

Has the child attended camp before? Yes No If yes when 2007, 2006, 05, 04, 03 ,02, 01

Parent(s) Name: _____

Is a sibling or family member attending or volunteering for camp? Yes _____ No_____

If so Name of individual _____

Emergency Phone # Day: ( ) _____Evening: ( ) _____

MILITARY SPONSOR INFORMATION

MUST BE COMPLETED !!!!!!!!

NAME: _____Rank: _____ (circle) Active / Retired

SERVICE MEMBER'S SSN: _____ - _____- _____

CURRENT UNIT: _____

RELATIONSHIP TO APPLICANT: _____

IF retired, what unit: _____ Date Retired: _____

Sponsor Status (Circle one): NJARNG / NJANG / NJ DMAVA Employee

Applications must be received complete including Part A and Part B of Medical Forms, copy of birth certificate and application fee. Incomplete applications will be returned and not considered for acceptance until complete. Physicals must be less then 2 years old to be valid.

18 Dec 07

PLEASE READ AND SIGN THE FOLLOWING INFORMATION!!!!!!!!!

I hereby voluntarily waive any claim against the New Jersey National Guard, the department of Military and Veterans Affairs or the United States of America for any or all causes which may arise in connection with my participation or my child's participation in the New Jersey National Guard summer Youth Camp.

_____ _____

Child Name **Parent/Guardian Name**

_____

Parent/Guardian Signature **Date**

I understand that the National Guard Youth Program is developing photographic and multimedia materials, which illustrate activities at the National Guard Youth Camp. I grant the National Guard Youth Program and its associated staff and subordinate entities, the right to take, use, reproduce, assign and/or distribute photographs, films, videotapes, sound recordings and non-confidential information of the youth for use in any such materials as the National Guard Youth Program or its associated entities may create, without any payment to or future approval by me. I concur that there shall be no payment for such use.

_____ _____

Child Name **Parent/Guardian Name**

_____

Parent/Guardian Signature **Date**

NJNG YOUTH CAMP HEALTH HISTORY AND EXAMINATION FORM

PART A TO BE COMPLETED BY THE PARENT/GUARDIAN

CAMPERS NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

DATE OF BIRTH: _____/_____/_____ PLACE OF BIRTH: _____

Parent/Guardian Name: _____ Relationship: _____

Telephone # Home: ( ) _____Work: ( ) _____

Name, address and phone number of nearest next of kin (other than Parent/Guardian):

Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone: ( ) _____

INSURANCE CARRIER: _____

Policy # _____

HEALTH HISTORY (COMPLETED BY PARENT/GUARDIAN)	YES	NO
1. Is the child under a physician's care now?	___	____
if yes, explain _____		
2. Has this child ever been medically advised not to participate in any kind of sports?	___	____
3. Is this child medically excused from physical education at the present?	___	____
4.Has He/She…		
a. Ever been unconscious after and injury?	____	____
b. Ever had a fracture or dislocation?	____	____
c. Ever had any surgery?	____	____
d. Within the last year, had to stay in a hospital overnight?	____	____
e. Ever experienced frequent chest pains or palpitations?	____	_____
f. Ever experienced high blood pressure?	____	_____
5. Does this child. . .		
a. Have a history of fainting with exercise?	____	____
b. Have a history of tiredness/fatigue?	____	____
c. Take any medications every day?	____	____
d. Have any allergies, including bee stings, hives, asthma?	____	____
e. Have a family history of sudden unexplained death under age 40?	____	

	YES	NO
6. Do you have any worries about his/her health or think that there may be any reason why he/she cannot participate in sports?	____	_____
7. List any malfunctions or absence of a paired organ (eyes, kidneys, testes, etc).		
8. Please list and explain any illness, injury, surgery, allergies and /or medications since his/her last physical.		
9. Has your child been designated as a "special needs" child in his/her school district or defined as having "Attention Deficit Disorder".	____	_____

PLEASE EXPLAIN ALL YES ANSWERS:

Signature of Parent _____ Date _____

PART B **TO BE COMPLETED BY PHYSICIAN**

IMMUNIZATION RECORD

Name of Child (Last, First, MI)	**Birth Date (Mo, Day, Yr)** / /	**Sex** ☐ **Male** ☐ **Female**
PARENT/ GUARDIAN	**Name**	**Phone ( )**
	Address	

VACCINE TYPE	**DISEASE DATE**	**1ST DOSE Mo/Day/Yr**	**2nd DOSE Mo/Day/Yr**	**3rd DOSE Mo/Day/Yr**	**4th DOSE Mo/Day/Yr**	**5th DOSE Mo/Day/Yr**	**6th DOSE Mo/Day/Yr**
Diphtheria, Tetanus, Pertussis - DPT *if DT or TD, indicate in corner box		☐	☐	☐	☐	☐	☐
Oral Polio Vaccine (OPV) if Salk Vaccine, Indicate (IPV) in corner		☐	☐	☐	☐	☐	☐
MMR (Measles, Mumps & Rubella)							
Measles					Measles or Serology	Date	Titer
Rubella					Measles or Serology	Date	Titer
Mumps					Measles or Serology	Date	Titer
Hepatitis B _____ _____ **Other**	_____	_____	_____	_____	_____	Date _____	_____

DT Requires valid medical exemption	Provisional admission attached ☐ Date Granted:	Medical exemption attached ☐	Religious exemption attached ☐

TB Screening (Mantoux Test)	Date	Date	Date
Tested	_____	_____	_____
Read	_____	_____	_____
Result (MM)	_____	_____	_____

Chest X-Ray Date	Result Normal	Abnormal
_____	_____	_____
_____	_____	_____
_____	_____	_____

Therapy
Case ☐ Reactor ☐
Date Started _____
Date Completed _____

HEALTH CARE RECOMMENDATION BY LICENSED PHYSICIAN

** I have examined the above camp applicant **within the past two (2) years**
Date Examined: _____/_____/_____

In my opinion, the above applicant ____is ____is not fit to participate in an active camp program.

The applicant is under the care of a physician for the following condition: _____
_____

Current Treatment (Include current medications, attached medication form): _____
_____

Explanation of any reported loss of consciousness, convulsion or concussion: _____
_____

Does applicant have epilepsy? Yes _____ No _____ Diabetes? Yes _____ No _____

Any treatment to be continued at amp_____
_____

Recommendations and Restrictions while at camp _____

PHYSICIAN SIGNATURE: _____ DATE: ___/_____/____
Printed Name: _____ Phone #: ( ) _____ - _____

18 Dec 07

STANDING ORDERS

for

OVER – THE – COUNTER MEDICATIONS

For NJ National Guard Youth Camp Campers and Staff

NAME: _____

ALLERGIES: _____

BENADRYL	12.5 mg 1-2 tabs PO q6 hours, as needed.
TUSSAFED	Ex.Srup 1 Tsp. PO q6 hours as needed
TYLENOL	325 mg 1-2 tabs PO q4 hours PRN headache, temp >101, generalized pain.
MOTRIN	200 mg 1-2 tabs PO q6 hours PRN headache, temp >101, generalized pain.
MYLANTA	over 48 pounds: 1-2 tabs (or 1-2 tsp) PO q1 hour PRN upset stomach, gas. DO NOT EXCEED 6 tablets (or 6tsps) per 24 hours.
TUMS	1-2 tabs PO q1 hour PRN upset stomach, gas.
ULTRA	DO NOT EXCEED 6 tablets per 24 hours.
1%HYRDRO-CORTISONE CREAM	Apply to affected area sparingly BID PRN itch.
PEPTO-BISMAL	1-2 tabs PO PRN upset stomach

Physician Signature: _____ Date: _____

Print: _____

Legal Guardian Signature: _____Date: _____

Print: _____

Dear Parent or Guardian,

1. No medication, prescription or non-prescription drugs (cough drops, aspirin, Tylenol, etc.) will be given to a child by the nurse unless it is received in the original container and accompanied by a written physicians **and** parental/guardian request.
2. All medications are to be held in the nurse's office with the parent/guardian assuming the responsibility for delivering such and picking up unused amounts at the end of Camp.
3. Prescription medication **must** be in the original pharmacy-labeled container.
4. Opportunities must be provided for child/parent/physician/nurse communications.
5. The physician must be consulted by the nurse whenever necessary to discuss medications being given to campers, including long-term use and possible abuse of any over-the counter medications.
6. **No camper** will be allowed to medicate him/herself during the camp.

COMPLETED APPLICATIONS ARE ACCEPTED ON A FIRST COME, FIRST SERVE BASIS. PLEASE MAIL TO:

Joint Force Headquarters
ATTN: Family Programs
3650 Saylors Pond Road
Fort Dix, NJ 08640

For more information, please call the State Family Programs Office at 609-562-0636. You will receive your confirmation packet by mail with your time to report.
www.state.nj.us/military/familysupport/

PERMISSION TO MEDICATE FORM

An authorization form is required to be signed by the physician and the parent/guardian of any child who must receive medication during camp.

NAME OF CAMPER: _____

NAME OF PHYSICIAN: _____

NAME OF MEDICATION: _____

_____

TIMES AND DOSAGE TO BE TAKEN: _____

_____

LENGTH OF TIME MEDICATION WILL BE REQUIRED: _____

_____	_____	_____
DATE	NAME OF PHYSICIAN	SIGNATURE OF PHYSICIAN

_____	_____	_____
DATE	NAME OF PARENT	SIGNATURE OF PARENT

NOTARY: _____

Date/Stamp/Seal

THIS FORM MUST BE RETURNED TO THE NURSE DURING IN-PROCESSING IF YOUR CHILD REQUIRES ANY MEDICATION WHILE ATTENDING CAMP. DO NOT RETURN WITH MAIN APPLICATION. THIS FORM MUST BE NOTARIZED!!

MEDICAL EMERGENCY AUTHORIZATION
THIS FORM MUST BE COMPLETED OR CHILD WILL NOT BE ABLE TO ATTEND CAMP.
THIS FORM MUST BE NOTARIZED !!!!!!!!

In case of sudden illness or an accident to the below named participant, requiring immediate treatment or surgery while participating in the NJ National Guard Youth Camp Program, I authorize the Primary Staff or Medical Staff to take such action as deemed appropriate to protect the health and physical well-being of my child. This authority extends to any physician(s) and /or surgeons(s) selected by the Primary Staff to perform medical and/or surgical procedures including examination and tests necessary to preserve the life and well-being of my child.

All efforts will be made to contact the parent(s) or guardian(s) in case of an emergency.

Name of child: _____

Parent or Guardian: _____

_____

(Parent or Guardian Signature)

Address: _____

City, State, Zip: _____

Phone Number: _____

Work Number: _____

Cell Phone/Pager Number: _____

Doctors Name: _____

Doctor Phone Number: _____

Notary: _____

Date/Stamp/Seal

*******THE ABOVE MEDICAL EMERGENCY AUTHORIZATION STARTS ON 12 July AND EXPIRES ON 19 July 2008 UPON THE COMPLETION OF CAMP*******

YOUTH CAMP APPLICATION ENCLOSURES
CHECK LIST

MAIN APPLICATION ☐

PART A EXAMINATION FORM ☐

PART B IMMUNIZATION RECORD ☐

STANDING ORDERS for Over Counter Medications ☐

PERMISSION TO MEDICATE (Bring to In-Processing)

MEDICAL EMERGENCY AUTHORIZATION ☐

COPY OF BIRTH CERTIFICATE ☐

CHECK FOR $100.00 (all campers ages 9-13)

(PAYABLE TO NJNG FAMILY PROGRAMS LOCAL FUND) ☐

PLEASE CHECK OFF ALL THE ABOVE FORMS AND SEND WITH YOUR APPLICATION PACKET. ALL OF THE ABOVE IS **REQUIRED TO QUALIFY FOR A COMPLETE APPLICATION PACKET.**